

MODULE 3

Introduction to The EMDPRS and 32 Chief Complaint Types

TRAINEE TEXT	INSTRUCTOR NOTES
<p data-bbox="191 423 662 482">MODULE OBJECTIVES</p> <p data-bbox="198 537 883 570">Upon completion of this module, you will be able to:</p> <ol data-bbox="198 609 911 1275" style="list-style-type: none">1. Identify the three categories of protocols within an EMDPRS.2. Identify the design components of each protocol within the EMDPRS.3. Explain the purpose and kinds of information found in each of the components of the protocols of an EMDPRS.4. Discuss/identify the categories of medical complaint types.5. Describe the contents and structure of an EMDPRS.6. Demonstrate use of each of the thirty-two chief complaint cards using your locally approved EMDPRS. <p data-bbox="198 1360 634 1415">MODULE DURATION</p> <p data-bbox="204 1472 461 1504">Minimum 12 hours.</p>	<p data-bbox="964 537 1354 570">State the module objective(s).</p> <p data-bbox="964 821 1182 853"><TG PAGE 3-2></p> <p data-bbox="971 1465 1370 1498">For instructor information only.</p>

MODULE 3

Unit 1 Instructor Preparation

Following are a list of questions and/or topics which appear in Unit 1, for trainees to answer and discuss. Although information is provided in the Trainee Guide and Instructor Guide, you should be prepared to discuss these questions/topics and give additional information and examples, based on local agency guidelines and your experience.

1. Discuss the basic types of information and design components of an EMDPRS. (Be prepared to review the types of EMDPRSs used by local agencies in your region.)
2. Be sure to emphasize the importance of the Initial Survey/All-Caller Interrogation card.
3. Stress getting a "call-back" number and why it is important.

MODULE 3
Unit 1 Instructor Preparation

TRAINEE TEXT	INSTRUCTOR NOTES
<p data-bbox="228 417 623 476">UNIT OVERVIEW</p> <p data-bbox="228 526 922 701">Aside from good telecommunications skills, good judgment and satisfactory operational equipment, the most important tool available to the EMD is the Emergency Medical Dispatch Protocol Reference System, aka EMDPRS.</p> <p data-bbox="228 738 943 1022">Unit 1, Introduction to the EMDPRS, teaches you to understand the basic concepts behind the development and arrangement of information in the EMDPRS. You will learn that all EMDPRSs contain basically the same types of information, and in relatively the same order. By learning the types of information found in an EMDPRS, you will be able to quickly understand and use <i>any</i> EMDPRS.</p> <p data-bbox="228 1098 618 1157">UNIT OBJECTIVES</p> <p data-bbox="228 1207 558 1247">Unit Learning Objectives</p> <p data-bbox="228 1284 867 1323">Upon completion of this unit, you will be able to:</p> <ol data-bbox="228 1356 943 1672" style="list-style-type: none">1. Identify the three categories of protocols within an EMDPRS.2. Identify the design components of each protocol within the EMDPRS.3. Explain the purpose and kinds of information found in each of the components of the protocols of an EMDPRS.	<p data-bbox="1000 532 1224 572"><TG PAGE 3-3></p> <p data-bbox="1000 607 1252 646">Introduce the unit.</p> <p data-bbox="1000 1218 1295 1290">State the unit learning objective(s).</p>

Module 3 - Unit 1
Introduction to the EMDPRS

TRAINEE TEXT	INSTRUCTOR NOTES
<p>Enabling Learning Objectives</p> <p>To meet the unit learning objectives, you will:</p> <ul style="list-style-type: none">1.1 Identify the three types of protocols within an EMDPRS.1.2 Describe the differences in content between the three types of protocols within an EMDPRS.2.1 List and describe the major sections of protocols within an EMDPRS.3.1 Describe the types of information gathered or provided, for each section, for each of the three types of protocols within an EMDPRS.	<p><TG PAGE 3-4></p>

TRAINEE TEXT	INSTRUCTOR NOTES
<p style="text-align: center;">Introduction to EMDPRS Structure and Layout</p> <p>The Emergency Medical Dispatch Protocol Reference System (EMDPRS) is frequently referred to as "guidecards, protocol cards, scripts or cards."</p> <p>Every agency has its own set of locally medically approved protocols. Their structure and contents vary from agency to agency, but overall they tend to contain similar information. It is up to you to practice regularly with the EMDPRS used by your agency.</p> <div style="border: 1px solid black; padding: 5px;"><p>NOTE: This unit illustrates the types of information found on most EMDPRS cards. <i>The EMDPRS sample pages you will receive while training on this unit are generic and are not approved for use once you return to your agency.</i> Locally approved cards will be reviewed at the end of this unit.</p></div> <p>EMDPRS protocols are designed to present medical information in a logical and structured sequence. The order in which the information is shown on protocols will vary, based on the information that your local medical advisory personnel determines to be most important.</p> <p>Descriptions of Three Protocol Types. Generally, all EMDPRS contain, at a minimum, three protocol types. Each of these protocols is designed to meet a specific need. These needs are described on the following pages. The protocol types are as follows:</p>	<p><TG PAGE 3-5></p> <p>Introduce the unit.</p> <p>Tell trainees that each agency has its own set of locally approved protocols.</p> <p>Hand out sample EMDPRS pages and tell trainees that these are only samples and not approved for use back at their sites. These are found at the end of this unit.</p> <p>Tell trainees that the EMDPRS is arranged logically, to present a structured sequence.</p> <p><TG PAGE 3-6></p>

Module 3 - Unit 1

Introduction to the EMDPRS

TRAINEE TEXT	INSTRUCTOR NOTES
<p>1. The Initial Survey/All-Caller Interrogation Protocol. This protocol is used to conduct the initial questioning of all callers, in an effort to gather criteria that help you to focus your information gathering activities.</p> <p>The initial survey protocol lists the questions to be asked of every caller. Questions are used to gather location (including telephone number) and patient status information (like patient age, status of breathing and level of consciousness). The information you get from the caller forms the basis for dispatch, information dissemination and further inquiry (as indicated by the EMDPRS).</p> <p>It is very important that you use this card for every call you take. This card points you to the proper protocol card and helps you focus the caller. It is the very first step in getting the <i>Where, What, How, Who, When</i> information you need for effective dispatch.</p> <div data-bbox="196 1218 911 1738" style="border: 1px solid black; padding: 10px; margin: 10px 0;"><p style="text-align: center;">Initial Survey</p><ul style="list-style-type: none">▶ Used to conduct initial questioning of caller▶ Asked of every caller▶ Location and Chief Complaint Data<p style="text-align: right; font-size: small;">3-1-1</p></div>	<p>Show Figure 3-1-1.</p> <p>Describe the Initial Survey/All-Caller Interrogation protocol.</p> <p>Stress the importance of using this card for every call.</p> <p><TG PAGE 3-7></p> <p>Show Figure 3-1-2.</p>

TRAINEE TEXT	INSTRUCTOR NOTES
<p>2. The Individual "Chief Complaint" Protocol. The individual "chief complaint" protocol is used to get information from all callers regarding the type and severity of medical emergency being reported.</p> <p>The individual "chief complaint" protocol is used by EMDs to verify (and get more) information on the chief medical complaints being reported by callers.</p> <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> <p style="text-align: center;">Individual Chief Complaint Protocol</p> <ul style="list-style-type: none"> ▶ Used to get information regarding type/severity of medical emergency ▶ Used to verify information gathered during all-caller interrogation <p style="text-align: center; font-size: small;">3-1-2</p> </div> <div style="border: 2px solid black; padding: 10px; margin: 10px 0;"> <p>NOTE: Experience indicates that the information found in the thirty-two chief complaint types discussed during this training represent the majority of emergency medical conditions that are likely to be reported by callers. Remember, many programs will have different groupings of these thirty-two chief complaint types.</p> </div>	<p>Describe the Individual "Chief Complaint" Protocol.</p> <p style="text-align: center; font-weight: bold; margin: 20px 0;"><TG PAGE 3-8></p> <p>Tell trainees that it is generally accepted that there are 32 basic chief-complaint types. Not all agencies use thirty-two; some have more while others may have less and that it is a locally decided issue.</p>

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Introduction to the EMDPRS

TRAINEE TEXT	INSTRUCTOR NOTES
<p>Information found in each of the thirty-two chief complaint protocols. Each of the thirty-two protocols contains four major design components:</p> <p>a) <i>Key Questions and Inquire of Caller.</i> The purpose of these two sections is to gather additional, specific information not received or asked for by the initial survey protocol.</p> <p>The "Key Questions" section lists important questions that you need to ask in order to gather additional medical information about the patient's condition.</p> <p>The "Inquire of Caller" section is used to help guide callers into giving you better, clearer information. Caller responses to these questions give you the information you need to determine the appropriate telephone medical instructions to give callers when (and if) required.</p> <p>b) <i>Dispatch Priorities (aka "Medical Dispatch Criteria").</i> The "Dispatch Priorities" section identifies the proper types of response allocations that are appropriate to the situation. Responses are prescribed and approved by the local Medical Director.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>NOTE: You should be able to dispatch the proper medical response to the scene based on the information gathered in the "Key Questions" section.</p> </div>	<p>Show Figure 3-1-3.</p> <p>List and describe the four major design components of the chief complaint protocols.</p> <ol style="list-style-type: none"> 1. Key Questions/Inquire of Caller <p><TG PAGE 3-9></p> <ol style="list-style-type: none"> 2. Dispatch priorities <p>Tell trainees that they should be able to dispatch resources based only on the information gathered through the "Key Questions" section.</p>

Module 3 - Unit 1

Introduction to the EMDPRS

TRAINEE TEXT	INSTRUCTOR NOTES
<p>c) <i>Pre-Arrival Instructions.</i> The purpose of this section is to list the basic information that you should give callers. It does not include medical instructions. It also helps you prepare callers for the arrival of the medical personnel you dispatched.</p> <p>d) <i>Useful Information.</i> This section gives you additional information about the medical situation including insights and possible complications.</p>	<p>3. Pre-arrival instructions</p> <p>4. Useful Information</p>
<p>NOTE: The information in the "Useful Information" section is designed specifically to expand your knowledge, relative to the chief complaint type being reported by the caller. It is not intended to be shared with callers.</p>	<p><TG PAGE 3-10></p> <p>Tell trainees that the information found in the Useful Information section is designed for the EMD's benefit and generally isn't shared with the callers.</p>
<p>An example of the Individual "Chief Complaint" Protocol is the ABDOMINAL PAIN/INJURY card.</p>	
<p>Information Groups Found on All Chief Complaint Types</p> <ul style="list-style-type: none"> ▶ Key Questions and Dispatch Priorities ▶ Inquire of Caller ▶ Pre-Arrival Instructions ▶ Useful Information <p style="font-size: small;">3-1-3</p>	

Module 3 - Unit 1
Introduction to the EMDPRS

TRAINEE TEXT	INSTRUCTOR NOTES
<p>3. The "Scripted Medical Protocol." The "scripted medical protocol" is a special type of protocol. These protocols give scripted telephone medical instructions (i.e. - protocols) that you are supposed to give to callers when immediate care needs to be given to victims in order to save their lives.</p> <p>These must be read aloud to the caller, word-for-word. The instructions that you give callers help them apply life-saving treatments to the victim prior to the arrival of dispatched responders.</p> <p>Examples of the scripted medical protocol are the CPR, CHOKING, CHILDBIRTH and AIRWAY MANAGEMENT cards. These protocols contain the scripts you would use to provide telephone medical instructions to callers in this situation.</p> <p>The scripted medical protocol may include additional information that can help you motivate and encourage callers to follow the instructions, to describe precautions callers should take and describe signs that callers can look for while administering telephone directed medical treatment provided by the EMD.</p>	<p>Describe the scripted medical protocol.</p> <p><TG PAGE 3-11></p> <p>Give examples of scripted medical protocol cards (CPR, Childbirth, Choking, Airway Management).</p>

TRAINEE TEXT	INSTRUCTOR NOTES
<p style="text-align: center;">Scripted Medical Protocol</p> <ul style="list-style-type: none">▶ Has four major groupings plus 1 new section called "Protocol"▶ Protocol section gives telephone instructions in script format that EMD reads to caller▶ May contain additional information used to motivate callers, etc. <p style="text-align: right;">3-1-4</p>	
<p>Summary</p> <p>This unit has introduced you to the basic design and structure of an EMDPRS. You have been trained on the three card types (All-Caller Interrogation, Individual "Chief Complaint" Protocol, and Scripted Medical Protocol) and the major sections of the cards. This unit also trained you on the information types found in each section of a card.</p> <p><i>Remember, the cards you use back at your site must be approved by the medical director of your EMS system.</i></p> <p>The next unit introduces you to the thirty-two chief complaint types. Module 3, Unit 2 provides you with basic medical information for each complaint type. Also, you will be trained on the use of your local medical protocol card for each complaint type.</p>	<p><TG PAGE 3-12></p> <p>Review the unit. Ask for (and answer) trainee questions.</p>

Module 3 - Unit 1
Introduction to the EMDPRS

Initial Survey

- ▶ *Used to conduct initial questioning of caller*
- ▶ *Asked of every caller*
- ▶ *Location and Chief Complaint Data*

Individual Chief Complaint Protocol

- ▶ *Used to get information regarding type/severity of medical emergency*
- ▶ *Used to verify information gathered during all-caller interrogation*

Information Groups

Found on All Chief Complaint Types

- ▶ *Key Questions and Dispatch Priorities*
- ▶ *Inquire of Caller*
- ▶ *Pre-Arrival Instructions*
- ▶ *Useful Information*

Scripted Medical Protocol

- ▶ *Has four major groupings plus 1 new section called "Protocol"*
- ▶ *Protocol section gives telephone instructions in script format that EMD reads to caller*
- ▶ *May contain additional information used to motivate callers, etc.*

MODULE 3

Unit 2 Instructor Preparation

Following are a list of questions and/or topics which appear in Unit 2, for trainees to answer and discuss. Although information is provided in the Trainee Guide and Instructor Guide, you should be prepared to discuss these questions/topics and give additional information and examples, based on local agency guidelines and your experience.

1. Review the 32 chief complaint types and have local EMDPRS protocols available to use in class. (If trainees are from many different agencies, you might consider using multiple instructors and breaking the class into groups, so trainees from each agency have a chance to review the protocols used by their agency.)
2. Be sure to cover any specific pediatric considerations that are listed for each chief complaint.

MODULE 3

Unit 2 Instructor Preparation

Module 3 - Unit 2
Introduction to the 32 Chief Complaint Types

TRAINEE TEXT	INSTRUCTOR NOTES
<p data-bbox="212 454 610 519">UNIT OVERVIEW</p> <p data-bbox="212 570 906 707">Your position as an EMD requires familiarity with a large number of medical complaints. Experience indicates, however, that there are generally thirty-two complaints that occur most frequently.</p> <p data-bbox="212 744 915 923">Unit 2, Introduction to the 32 Chief Complaint Types provides you with general medical information about the thirty-two chief complaint types. You will review the information provided in this trainee guide and the information found in your locally approved EMDPRS.</p> <p data-bbox="212 1000 610 1065">UNIT OBJECTIVES</p> <p data-bbox="212 1109 548 1148">Unit Learning Objectives</p> <p data-bbox="212 1185 859 1225">Upon completion of this unit, you will be able to:</p> <ol data-bbox="212 1257 894 1574" style="list-style-type: none">4. Discuss/identify the categories of medical complaint types.5. Describe the contents and structure of an EMDPRS.6. Demonstrate use of each of the thirty-two chief complaint cards using your locally approved EMDPRS. <p data-bbox="277 1611 670 1651">Enabling Learning Objectives</p> <p data-bbox="277 1683 878 1723">To meet the unit learning objectives, you will:</p> <ol data-bbox="277 1755 922 1795" style="list-style-type: none">4.1 Identify the thirty-two chief complaint types.	<p data-bbox="987 454 1219 493"><TG PAGE 3-13></p> <p data-bbox="987 570 1235 609">Introduce the unit.</p> <p data-bbox="987 1109 1289 1188">State the unit learning objective(s).</p>

Module 3 - Unit 2
Introduction to the 32 Chief Complaint Types

TRAINEE TEXT	INSTRUCTOR NOTES
<p>4.2 Define/discuss the difference between a medical chief complaint, a traumatic chief complaint type and a time/life-critical chief complaint type.</p> <p>4.3 Discuss the difference between signs and symptoms.</p> <p>4.4 Describe how to identify "chief complaints."</p> <p>5.1 Discuss the purpose/focus of the questions for each category of chief complaint type (medical vs. traumatic vs. time/life-critical events).</p> <p>6.1 Demonstrate using the EMDPRS with a call about a specific complaint type.</p> <p>6.1.1 Identify critical elements in cardiac arrest survival.</p> <p>6.1.2 Describe the role of the EMD in providing telephone CPR.</p>	<p><TG PAGE 3-14></p>

Module 3 - Unit 2
Introduction to the 32 Chief Complaint Types

TRAINEE TEXT	INSTRUCTOR NOTES
<h2 style="margin: 0;">Introduction to The Chief Complaints</h2> <p style="margin: 10px 0 0 0;">A Quick Review of Important Concepts</p> <p style="margin: 0 0 0 0;">Overview of The Process. As you have already learned, every caller undergoes some sort of initial questioning to identify if the patient is conscious and/or breathing. In some systems this is called the "Initial Survey," the "All-Caller Interrogation" or "Entry Level Interrogation."</p> <p style="margin: 0 0 0 0;">Normally the process begins with the initial survey. This initial survey and the answers you receive from the caller direct you to the proper individual chief complaint card, which is followed by specific key questions as directed by the card. Once you get this information, you can make a decision on unit response configuration and mode and dispatch units to the scene. You can now return to the caller and begin the pre-arrival (post-dispatch) instructions required for the situation at hand.</p> <p style="margin: 0 0 0 0;">After the location and call-back number have been determined, you continue the initial assessment and get the patient's age, status of consciousness and status of breathing. If the patient is conscious or unconscious and breathing, the dispatcher immediately knows that the patient is alive and now has a little more time to get specific information from the caller about the patient's condition. This enables you to send resources in the proper response configuration and mode. This also allows you to give the caller accurate and useful pre-arrival (post-dispatch) instructions.</p> <p style="margin: 0 0 0 0;">If the patient is unconscious and not breathing, or if the patient is unconscious and the caller can't tell if the patient is breathing or not, you should assume a possible cardiac arrest situation exists and turn immediately to the appropriate protocol for the provision of CPR.</p>	<p style="margin: 0 0 0 0;"><TG PAGE 3-15></p> <p style="margin: 10px 0 0 0;">Show Figure 3-2-1.</p> <p style="margin: 0 0 0 0;">Review the EMD Process.</p> <ol style="list-style-type: none"> <li style="margin: 0 0 0 0;">1. Starts with Initial Survey. <li style="margin: 0 0 0 0;">2. After location and call-back is checked; get consciousness and breathing status. <li style="margin: 0 0 0 0;">3. If patient is unconscious or not breathing, go to CPR card.

Module 3 - Unit 2

Introduction to the 32 Chief Complaint Types

TRAINEE TEXT	INSTRUCTOR NOTES
<p>The CPR protocol has clear and understandable instructions that take the caller through airway interventions prior to the provision of chest compressions. If the patient has merely choked and is not in cardiac arrest, you need to provide the instructions for choking intervention rather than CPR. The design of the protocol guides you through this process.</p> <div data-bbox="188 731 906 1253" style="border: 1px solid black; padding: 10px; text-align: center;"><h4>Flow of Call Processing</h4><pre>graph TD; A([Caller places call for help]) --> B([EMD conducts initial survey]); B --> C([Based on information gathered, EMD forms to proper card]); C --> D([EMD gets clarifying information]); D --> E([EMD dispatches resources]); E --> F([EMD gives instructions as required]);</pre><p>3-2-1</p></div> <p>Caller emotional status. Remember that the caller's emotional status is not a clear indication of the medical problem's severity. You must adhere to the questions found on the protocol and make decisions based on the symptoms that are reported and the existence (or absence) of symptoms that indicate the need for a high priority response.</p> <p>The most common high-priority symptoms included in the majority of EMDPRS are chest pain, breathing problems, altered levels of consciousness and, in some cases, severe hemorrhage. In most cases, when these symptoms are reported, you will initiate a high level ALS response due to the potential severity of the situation.</p>	<p><TG PAGE 3-16></p> <p>Review this "caller emotional status" paragraph. Tell trainees that emotional state is not indicative of the problem severity.</p>

Module 3 - Unit 2
Introduction to the 32 Chief Complaint Types

TRAINEE TEXT	INSTRUCTOR NOTES
<p>Signs and Symptoms. As you may recall from Module 1, there is a difference between <i>signs</i> and <i>symptoms</i>. Signs are things that are found upon examining the patient. Examples of signs include thready pulse, spurting blood, cyanosis (turning blue) and diaphoresis (sweating). Symptoms are things that the patient complains of that s/he is feeling. Examples of symptoms include "I'm hot/cold," "I'm having a hard time breathing" and "I can't feel my toes."</p> <p>Identifying the Chief Complaint. This is part of the "initial survey." It is important to remember that the chief complaint is that which is most paramount on the patient's (or caller's) mind.</p> <p>Patients with multiple complaints will most frequently identify the chief complaint first and then go on to list the secondary complaints, many of which will be symptoms of the chief complaint. Asking "What's wrong?" often confuses the caller and causes them to assume you are asking for a diagnosis. Ask questions that elicit short and descriptive responses from the caller. They are your eyes at the scene, so ask them "What do you see? Tell me what is happening!"</p> <p>When a caller presents you with multiple chief complaints that seem to have no relationship with each other, you need to select the one that has the most potential to worsen or that has the highest priority symptoms.</p> <p>The Flow of Call-Processing. Your call-processing should follow a smooth pattern and logical flow. Normally the process begins with initial entry-level questioning, followed by specific key questions. Once this information is obtained the EMD can make a decision on unit response configuration and mode and dispatch units to the scene. The EMD can now return to the phone and begin the pre-arrival (post-dispatch) instructions required for the situation at hand.</p>	<p><TG PAGE 3-17></p> <p>Review signs and symptoms.</p> <p>Review the chief complaint identification.</p> <p>Review call processing flow.</p>

Module 3 - Unit 2

Introduction to the 32 Chief Complaint Types

TRAINEE TEXT	INSTRUCTOR NOTES
<p>Prior to terminating the phone call with the caller, the EMD should ensure that the patient has a clear airway and is breathing. You should also instruct the caller to turn patients gently on their side if they should vomit (unless spinal injury is suspected). In minor or less urgent cases, you need to tell the caller to call back if the patient's condition changes before help arrives.</p> <p>Medical Complaint Types: Individual Chief Complaints, Traumatic Incidents and Time/Life-Critical Events</p> <p>Generally speaking, there are two medical complaint types; <i>Individual Chief Complaints</i> and <i>Traumatic Incident Types</i>. In most cases, the calls you receive fall into these two categories. However, there is a subset of these calls that are also very important for you to know and understand. This subset is called the <i>Time (or Life) Critical Events</i>.</p> <p>Individual Chief Complaints. It is common to assume that all reported problems are individual chief complaints. In some respects that is the case. However, in the field of emergency medical dispatch, there is a distinction between individual chief complaints and traumatic incidents.</p> <p>Individual chief complaints typically are general medical problems. A medical problem is generally defined as "an illness, either acute or chronic." Proper response and pre-arrival instructions in these cases is based on your ability to gather information regarding:</p> <ol style="list-style-type: none">1. the patient's chief complaint;2. the patient's age;	<p><TG PAGE 3-18></p> <p>Show Figure 3-2-2.</p> <p>Introduce the two major medical complaint types.</p> <p>Introduce the "individual chief complaint types."</p> <p>Explain the difference between acute or chronic, as needed.</p>

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Introduction to the 32 Chief Complaint Types

TRAINEE TEXT	INSTRUCTOR NOTES
<p>the patients airway is clear, advising the caller when it may be best to do nothing, advising the caller to guide the units to the patient and advising the caller to call back if the patient's condition worsens.</p> <p>Specific Pediatric Considerations (Traumatic Incident Types). Accidents are the most common cause of death in childhood, killing more children than cancer, meningitis, congenital defects, and heart disease combined. Over three thousand deaths per year occur in infants (under the age of one) from falls, burns, drowning, choking and suffocation. For every accidental death, one hundred children are seriously injured.</p> <p>Traumatic incident types are by far the most common chief complaint grouping used to report incidents involving children. With regard to CPR and choking interventions, children should be defined clearly as an infant (0-1 years old); child (1-8 years old); or adult (> 8 years old) according to the American Heart Association and the American Red Cross. These conventions should be considered when your agency is developing continuing education or conducting initial training.</p> <p>In cases of traumatic injury the child should not be moved unless in danger. A common error made at the scene of an injury is for the caller to move or pick up the child, run into the house or shelter and hold the child to comfort him/her. This can prove to be devastating to the child with spinal injuries which can be worsened when the child is being moved by concerned but untrained bystanders. If the child has gotten up and run into the house, she should lie down on a flat surface and be comforted while being kept still and reassured by bystanders.</p> <p>A spinal cord injury should be suspected if there is any indication of:</p> <ol style="list-style-type: none"> 1. severe facial or head injuries; 	<p>Review specific pediatric considerations that relate to traumatic incident types.</p> <p>Ask trainees to identify other pediatric considerations they may know about.</p> <p><TG PAGE 3-22></p> <p>Tell trainees when to suspect pediatric spinal cord injuries.</p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ol style="list-style-type: none">2. unconsciousness reported associated with the incident;3. numbness, tingling or loss of sensation in any extremity(ies);4. paralysis or inability to move any extremities;5. pain in back upon movement or attempt to move or6. any motor dysfunction reported by the caller. <p>Children may have critical injuries, but the symptoms may remain hidden until the child reaches a point of rapid deterioration. Critical symptoms such as low blood pressure do not appear as rapidly in children as they do in adults. Other symptoms like breathing and pulse may be difficult to interpret in a child who is hurt or frightened. If priority symptoms are present, time is critical and the child must be taken immediately for care.</p> <p>Conscious injured children require extra attention, support and reassurance, preferably from a single consistent bystander. This must be communicated through the EMD to the bystander.</p> <p>Remember, <i>the emotional condition of the patient and/or caller should not be used as indicator of the severity of the problem.</i> Lacking experience and knowledge, children may not understand the severity of an incident and may appear to be very calm in the face of crisis. Likewise, bystanders and children may be distraught from witnessing the incident, reacting to the sight of blood or arms and legs bent at unnatural angles.</p> <p>Prevention is the most powerful treatment for most childhood injuries. The EMD can play a role in injury prevention by recognizing and reporting traffic, playground or other hazards as they are identified in calls relating to childhood injuries.</p>	<p>Tell trainees that children require extra attention.</p> <p>Tell trainees that EMDs should not use emotional status as a barometer of the problem's severity.</p> <p><TG PAGE 3-23></p>

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Introduction to the 32 Chief Complaint Types

TRAINEE TEXT	INSTRUCTOR NOTES
<p data-bbox="358 432 789 476" style="text-align: center;">Traumatic Incident Types</p> <ul style="list-style-type: none"><li data-bbox="337 541 808 598">▶ Based on some physical injury due to accident or violence<li data-bbox="337 628 656 663">▶ Responses based on...<ul style="list-style-type: none"><li data-bbox="363 685 651 720">· mechanism of injury<li data-bbox="363 716 711 773">· location of injury (core or extremity?) <p data-bbox="712 825 760 847" style="text-align: right;">3-2-3</p> <p data-bbox="212 969 911 1109">Time/Life-Critical Chief Complaint Types. These are a subset of individual chief complaints and traumatic incident types. They pose the greatest danger to the patient, bystanders and/or responders.</p> <p data-bbox="212 1153 894 1292">Care should be taken with these cases to ensure that appropriate pre-arrival (post-dispatch) instructions are given and that information regarding the safety of the scene is relayed to the responding units.</p> <p data-bbox="212 1336 911 1437">Calls of this type may be specifically medical in nature, like cardiac arrest, choking, childbirth, unconsciousness, CO poisoning/HAZMAT.</p> <p data-bbox="212 1480 911 1720">Others may have both types (traumatic and individual chief complaint) included in the problem. Examples include a drowning victim with respiratory difficulty and neck pain from a shallow water diving incident; an electrocution victim with possible internal burn who has fallen off the telephone pole and who also may have traumatic injuries from a long fall.</p>	<p data-bbox="979 978 1338 1043">Review the time/life-critical complaint types protocol.</p> <p data-bbox="979 1087 1235 1122">Show Figure 3-2-4.</p> <p data-bbox="979 1166 1409 1266">Tell trainees these complaints represent the greatest danger to the patient and bystanders.</p> <p data-bbox="979 1310 1409 1410">Tell trainees that it is vitally important to assure appropriate response to this complaint type.</p> <p data-bbox="979 1655 1211 1690" style="text-align: center;"><TG PAGE 3-24></p>

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<p>Proper call handling relies on your ability to gather information about the chief complaint. It also requires that you gather information about the safety of the scene and other important factors that may require you to dispatch ancillary agencies (like police, fire and/or HAZMAT units).</p> <p>Pre-arrival or post-dispatch instructions relate primarily to the scripted CPR, choking and childbirth instructions along with situational instructions for specific medical or traumatic incident types with a focus on scene safety.</p> <div data-bbox="212 856 932 1378" style="border: 1px solid black; padding: 10px;"><p style="text-align: center;">Time/Life-Critical Events</p><ul style="list-style-type: none">▶ Pose greatest danger to patient, bystanders or responders▶ Responses based on...<ul style="list-style-type: none">- scene safety information- police, fire, HAZMAT, etc. needs<p style="text-align: right;">3-2-4</p></div>	<p>Tell trainees that proper call handling relies on the ability to get information about the chief complaint, including any scene safety issues.</p>
<p>Philosophy of the Design and Use of the EMDPRS</p> <p>This unit presents chief complaint information in the order described below. Chief complaints are alphabetized within each of the following groupings:</p> <ol style="list-style-type: none">1. Traumatic Incidents;2. Individual Chief Complaints and3. Time/Life-Critical Events.	<p>Review EMDPRS design/use philosophy.</p> <p><TG PAGE 3-25></p> <p>Tell trainees that they will review the chief complaints in the order of Traumatic Incident, Individual Chief Complaint, and Time/Life-Critical events.</p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>NOTE: In the "real-world," each EMDPRS may be arranged differently based on the decisions made by the local medical authority. In most EMDPRSs, complaint types are arranged alphabetically.</p> <p>Philosophy of Use. When determining what an EMDPRS should look like or how it should be used, medical advisors consider the following questions. Should my EMDPRS be a strict protocol or a dispatch guideline? Should we mandate its use or make it optional?</p> <p>In your area, use of the EMDPRS may vary from someone who works in another agency or city. It is up to you to be aware of the policies your agency has set up for using the locally approved EMDPRS.</p> <p>Design Philosophy. In Unit 1 of this Module you were presented information on the design of EMDPRSs and were also given the opportunity to study the structure of your local EMDPRS. The major elements presented were:</p> <ol style="list-style-type: none">1. the Initial Survey/All-Caller Interrogation;2. the Individual Chief Complaint Protocol;<ol style="list-style-type: none">a. the "Key Questions" sections of a protocol and the information found there;b. the "Dispatch Priorities" section of a protocol and the information found there;c. the "Protocol" section that is found only on "Scripted Medical" protocols, and the information found there;d. the "Additional Useful Information" section and the information found there and	<p>Tell trainees that EMDPRSs are ordered differently, based on the direction of local medical authority. In most cases, however, the EMDPRS is arranged alphabetically.</p> <p>Tell trainees that EMDPRSs will vary from agency to agency.</p> <p>Review the major elements of EMDPRS design.</p> <p><TG PAGE 3-25></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>3. the Scripted Medical Protocol.</p> <p>Specific design characteristics of the EMDPRS. The EMDPRS is designed to maximize EMDPRS use and flow. The EMDPRS determines:</p> <ol style="list-style-type: none"> 1. the order that various actions are taken by the EMD; 2. when the EMD is to dispatch resources; 3. the mode (Hot vs. Cold) and configuration (Type of Unit or Units) of the response and 4. when the EMD is to provide instructions. <div style="border: 1px solid black; padding: 10px; margin-top: 20px;"> <p style="text-align: center;">EMDPRS Determines...</p> <ul style="list-style-type: none"> ▶ Order of EMD actions ▶ When to dispatch resources (types and configurations included) ▶ Assigns mode and configuration to responding personnel ▶ Tells when to give telephone medical instructions ▶ Tells when/how to end the call <p style="text-align: right; font-size: small;">3-2-5</p> </div>	<p>Show Figure 3-2-5. Review the specific design characteristics of the EMDPRS.</p> <p>Tell trainees that EMDPRS determines the order actions are taken, when to dispatch, mode and configurations of responses and when EMDs are to give medical instructions to callers.</p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p data-bbox="224 366 873 454">Detailed Review of the Thirty-two Chief Complaint Types</p> <p data-bbox="224 585 938 803">Traumatic Incident Types. Following is a detailed review of the eleven Traumatic Incident Type protocols. Your instructor will provide additional information about these, and then you will be given the opportunity to practice using your local EMDPRS protocol for the given chief complaint.</p>	<p data-bbox="992 366 1230 401"><TG PAGE 3-27></p> <p data-bbox="992 445 1414 554">Review the 32 chief complaints. See IG NOTE #1 for helpful hints, p. 3-135 of this guide.</p> <p data-bbox="992 591 1377 663">Review each of the following traumatic incident types.</p> <p data-bbox="992 701 1414 803">We suggest you review each traumatic incident type by going over the:</p> <ol data-bbox="992 847 1386 1174" style="list-style-type: none">1. background;2. common causes;3. common symptoms reported;4. instructions usually given and5. any special pediatric considerations the EMD should know. <p data-bbox="992 1218 1414 1362">Once you've reviewed these points (for <u>each</u> complaint type), review EMDPRS protocols for the members of your class.</p> <p data-bbox="992 1399 1377 1655">If trainees represent many different agencies, you might consider using multiple instructors and breaking the class into groups where EMDPRSs can be reviewed individually.</p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none">a. Monitor and maintain patients airway, especially if patient is nauseated or vomiting.b. Treat for shock:<ul style="list-style-type: none">1) Control bleeding.2) Lay patient on left side (recovery position) EXCEPT IN SPINAL INJURY SITUATIONS; allow patient to assume a comfortable position.3) Keep patient warm.4) DO NOT GIVE PATIENT FOOD OR DRINK.c. Control bleeding with direct pressure.d. Call back if the patient's condition changes before help arrives.e. For snake bites, DO NOT ELEVATE THE BITTEN AREA, DO NOT USE ICE and DO NOT ATTEMPT TO REMOVE VENOM IN ANY WAY. Reassure caller that most snake bites are not life-threatening.f. Regardless of how minor the bite seems to be, patients should be advised to seek medical attention.g. Lock all pets away because they may interfere with instructions given or attack responding personnel.	<p style="text-align: center;"><TG PAGE 3-29></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none"> a. Children are common victims of pet bites, and their smaller size and uncontrolled reactions to animals make them more likely than adults to suffer serious facial injuries. b. In situations where envenomation (venom injected into bloodstream) is possible through snake, fire ant, scorpion and spider bites, children will commonly suffer more severe reactions, including death, than will adults. <p>2 - Assault/Sexual Assault (Traumatic Incident Type)</p> <p>1. Background:</p> <ul style="list-style-type: none"> a. These chief complaints often pose a danger to the responders and the bystanders as well. b. Sexual assaults often are accompanied by traumatic injuries. The EMD should assume there are physical injuries in these cases. c. The victim should be protected from further injury if possible. d. Information should be relayed to responding crews regarding scene security, particularly if the assailant is nearby. In these cases, responders should be advised to stay away until the police secure the scene and the evidence. 	<p>Review the Assault/Sexual Assault complaint type.</p> <p><TG PAGE 3-30></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>4) DO NOT GIVE PATIENT FOOD OR DRINK.</p> <p>c. Control bleeding with direct pressure.</p> <p>d. Call back if the patient's condition changes before help arrives.</p> <p>e. Lock all pets away because they may interfere with instructions given or attack responding personnel.</p> <p>5. Special Pediatric Considerations:</p> <p>a. Most pediatric cases of assault/sexual assault are reported as child abuse situations. Twenty-five percent of child abuse cases involve patients under the age of two leaving seventy-five percent in all other age groups up to the age of sixteen. Twenty percent of physically abused children are permanently injured.</p> <p>b. Intentionally inflicted injury is one of the leading causes of death in children under 5, with over 2000 deaths annually in the US. However, the call to EMS will rarely describe the incident as assault or abuse. EMS providers should therefore always be alert to the possibility that what appears to be an accidental injury in a young child may have in fact been inflicted. Pediatric cases of assault/sexual assault should be reported as child abuse. In most states EMS providers are considered mandated reporters of suspected child abuse or neglect and as such, in most states, are protected against charges of libel when reporting suspected child abuse.</p>	<p><TG PAGE 3-32></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">b. Chemical burns from an acid or lye compound.c. Electrical burns from an electrical source. <p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none">a. Burns are usually very painful as described by the caller.b. The caller may describe blistering or the peeling off of skin.c. Patients with electrical burns may be described as unconscious. If this is the case assume cardiac arrest and prepare to perform CPR. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none">a. Monitor and maintain patient's airway, especially if patient is unconscious.b. Cool small burns (ten percent or less total body area) with clean water.c. If the patient is still burning, extinguish flames with water or roll patient in a blanket or whatever is handy. DO NOT REMOVE BURNT CLOTHING.d. Do not apply anything to the burned area. Attempt to keep it clean and the patient covered.e. Continuously irrigate or flush all household chemical burns with water until help arrives.f. Caution caller to be aware of electrical hazards if electrical burn is reported. Be	<p style="text-align: center;"><TG PAGE 3-35></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>particularly aware of electrified water. If the patient is still in contact with the electrical source do not touch them.</p> <p>g. Treat for shock:</p> <ol style="list-style-type: none">1) Control bleeding.2) Lay patient on left side (recovery position) EXCEPT IN SPINAL INJURY SITUATIONS.3) KEEP PATIENT WARM (maintain body temperature). <p>h. In cases of Industrial chemical exposure, contact HAZMAT resources according to local HAZMAT procedures.</p> <p>i. DO NOT GIVE THE PATIENT ANYTHING TO EAT OR DRINK. In cases of internal burns from a caustic ingestion from an acid or lye, advise giving the patient water to dilute the chemical if possible.</p> <p>j. Call back if the patient's condition changes before help arrives.</p> <p>k. Lock all pets away because they may interfere with instructions given or attack responding personnel.</p> <p>5. Special Pediatric Considerations:</p> <ol style="list-style-type: none">a. Electrical burns, chemical, thermal burns and scaldings are the most common burns in children.b. Scald burns common to the toddler aged child frequently cause more extensive damage than a similar burn in an adult or older child because the skin is thin. Scald	<p><TG PAGE 3-36></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>with sufficient force to go through the eye and into the cranium. This may result in an underlying head injury. If the level of consciousness is dropping or altered this should be suspected.</p> <p>b. The fluids in the eye are very fragile. If the eyeball is cut open or leaking fluid then it should not be touched or bandaged. The caller should be advised to not put direct pressure on the eye to arrest bleeding. The patient should sit up and be calmed until help arrives.</p> <p>c. Chemicals and foreign bodies are common injuries to the eye. The eye should be irrigated with room temperature water until help arrives.</p> <p>d. The caller should not attempt to remove any impaled objects in the eye. This may cause further damage to the eye.</p> <p>2. Common Causes:</p> <p>a. Severe eye injuries include penetrating wounds to the eye, lacerated eyes, retinal detachments and eye injuries associated with lowered levels of consciousness possibly indicative of an underlying head injury.</p> <p>b. Common moderate eye problems include chemicals in the eye, arc welding burns and other thermal burns of the eye.</p> <p>c. Minor eye problems include contact lens problems, foreign bodies, corneal abrasions and contusions from orbital fractures (fractures of the bones surrounding the eye).</p>	<p><TG PAGE 3-38></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>3. Common Symptoms Described by Caller (presentation)</p> <ul style="list-style-type: none"> a. Severe pain and discomfort. This is particularly true with foreign bodies in the eyes. b. Bleeding is usually minimal unless surrounding facial trauma is associated with the injury. c. If the eyeball itself has been lacerated or punctured there may be a pinkish fluid leaking out of the eye. This may be the fluid within the eye and the caller should be advised to do nothing to treat this injury until help arrives. Tell the caller NOT to bandage the eye, or put any pressure on it. d. Penetrating object visible. Advise the caller not to remove the penetrating object. <p>4. Instructions Commonly Provided:</p> <ul style="list-style-type: none"> a. Monitor and maintain patient's airway, especially if patient has lowered level of consciousness. b. Allow patient to assume a comfortable sitting position. c. If the patient has a small foreign body (like dust or small dirt particles) or a chemical in the eye, it should be irrigated until help arrives. Have the caller irrigate the eye under a steady stream of room temperature water and irrigate the eye with the injured eye downhill from the nose. If the eye is being irrigated outside with the water hose, advise the caller to run the water 	<p><TG PAGE 3-39></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>until any hot water in the hose has been flushed out to prevent further injury to the patient.</p> <p>d. If the eyeball is cut or leaking fluid it should not be touched, bandaged or otherwise disturbed by bystanders. The patient should be made to sit up and be calmed until help arrives.</p> <p>e. Treat for shock:</p> <ol style="list-style-type: none">1) Keep patient warm (maintain body temperature).2) DO NOT GIVE PATIENT FOOD OR DRINK. <p>f. Call back if the patient's condition changes before help arrives.</p> <p>g. Lock all pets away because they may interfere with instructions given or attack responding personnel.</p> <p>5. Special Pediatric Considerations:</p> <ol style="list-style-type: none">a. A child with an isolated eye injury is best transported with a parent or other familiar adult to help maintain the position of comfort. Attempts to restrain the child may elevate intraocular pressure.	<p><TG PAGE 3-40></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>5 - Fall Victim (Traumatic Incident Type)</p> <p>1. Background:</p> <ul style="list-style-type: none">a. This protocol is useful for falls where back or other injuries have occurred.b. A long fall may be considered any fall that exceeds the height of the patient. Falls of greater than six feet are often considered long falls.c. With any long fall the EMD should suspect that a spinal injury exists and use spinal precautions in providing telephone aid.d. Long falls are usually third party in nature requiring the EMD to provide instructions through the third party.e. Falls may have been preceded by a medical incident. This information should be relayed to the responding personnel.f. The length of the fall is the easiest determinant of severity. The EMD must be mindful that external trauma as well as internal injury may exist.g. Any fall victim reported to be unconscious or with associated head or facial injuries should be assumed to have a spinal cord injury. Do not move the patient.h. Falls in the elderly resulting in hip or wrist fractures are a common call.	<p>Review the Fall Victim complaint type.</p> <p><TG PAGE 3-41></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none">i. Ground level falls resulting in minor injury are another common call you will receive.2. Common Causes:<ul style="list-style-type: none">a. Medical causes such as epilepsy, CVA (stroke), fainting, etc.b. Industrial and construction accidents.c. Environmental factors like ice, snow, alcohol, drugs, etc.3. Common Symptoms Described by Caller (presentation)<ul style="list-style-type: none">a. Visible external trauma.b. Numbness, tingling or loss of movement in cases of associated spinal cord injury.c. Anxiety due to the mechanism of injury.4. Instructions Commonly Provided:<ul style="list-style-type: none">a. Monitor and maintain patient's airway, especially if the patient has a decreased level of consciousness.b. Do not move the patient, do not splint the injuries or otherwise disturb the patient unless there is an airway compromise.c. Treat for shock:<ul style="list-style-type: none">1) Keep patient warm (maintain body temperature).2) DO NOT GIVE PATIENT FOOD OR DRINK.	<p style="text-align: center;"><TG PAGE 3-42></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<ul style="list-style-type: none"> d. Use direct pressure to control external bleeding. e. Call back if the patient's condition changes before help arrives. f. Lock all pets away because they may interfere with instructions given or attack responding personnel. <p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none"> a. Some special categories of falls exist for children, including walker falls, playground falls, falls from buildings and inflicted injury attributed to an accidental fall. b. Toddlers and infants can sustain skull fractures and potential brain injury in falls under four feet <i>if the contact surface is not shock-absorbing</i> (i.e., falls from shopping cart to a concrete or tile surface, from beds or changing tables to uncarpeted floors, or down uncarpeted stairs in a walker). c. The severity of playground injuries relates to the height of play structures and the shock absorbing qualities of the contact surface. d. Accidental falls from windows happen commonly during the summer months and can be prevented by window guards, but children also fall from windows because they are pushed or because they are deliberately jumping to escape perceived threat or to attempt suicide. e. Injuries attributed to a fall from a mechanism that is not developmentally likely or possible may be due instead to child abuse/inflicted injury. (An example 	<p><TG PAGE 3-43></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>might be a one month old said to have fallen from the changing table, at an age when most infants cannot roll from back to stomach.)</p> <p>6 - Heat/Cold Exposure (Traumatic Incident Type)</p> <p>1. Background:</p> <ul style="list-style-type: none">a. Heat related problems can be classified as either heat exhaustion or heat stroke, the latter representing a more serious situation.b. Heat exhaustion is caused by a metabolic imbalance resulting in flu like symptoms such as pallor, nausea and vomiting. In this case the patient should be moved to a cooler environment and be given fluids to drink (UNLESS THE PATIENT IS NAUSEOUS OR VOMITING). Heat exhaustion usually is secondary to outside exertion in hot and humid weather.c. In cases of heat stroke the body loses it's ability to thermoregulate itself. The body core temperature rises and the patient's level of consciousness decreases. Frequently, the patient will feel hot and dry to the touch, though they may also be profusely sweating (if they were engaged in some physical exertion). In some cases, the skin will appear reddened. The patient should be moved to a cooler environment and cooled with water. The patient should not be given fluids or anything to drink.d. Cold related problems are usually frost bite or hypothermia, the latter representing the more serious situation.	<p><TG PAGE 3-44></p> <p>Review the Heat/Cold Exposure complaint type.</p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>4. Instructions Commonly Provided in addition to those noted previously:</p> <ul style="list-style-type: none">a. Monitor and maintain patient's airway, especially if patient is nauseated or vomiting or if the level of consciousness is decreased.b. Treat for shock:<ul style="list-style-type: none">1) Control bleeding.2) Lay patient on left side (recovery position) EXCEPT IN SPINAL INJURY SITUATIONS.3) Keep patient warm (or cool, depending on the exposure being treated).c. Do not give the patient anything to eat or drink except in cases of heat exhaustion (and if the patient is not vomiting or nauseous) when the patient is benefitted by fluids. Never give anything to drink to the patient with a decreased level of consciousness.d. Gather or list the patient's medications for the doctor.e. Call back if the patient's condition changes before help arrives.f. Lock all pets away because they may interfere with instructions given or attack responding personnel.	<p><TG PAGE 3-46></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>5. Special Pediatric Considerations:</p> <ul style="list-style-type: none">a. Pediatric complaints of this type are rare and often are presented to the EMD as frostbite or chilblains (itching inflammations of the skin due to exposure to moist cold) on exposed tissues such as the fingers, feet and ears. Treatment from the EMD should be limited to getting the patient out of the cold environment and attempting to rewarm the extremity by means other than rubbing the affected tissues.b. Heat related complaints usually are presented to the EMD as a "sick child" with flu like symptoms, dehydration from playing in the hot outdoors and slight heat exhaustion. Treatment includes removing the patient from the hot environment and providing fluids (if not nauseous or vomiting).c. Children are more slow to acclimate to hot or humid weather than adults and become dehydrated more rapidly. Children particularly at risk for environmental or exertion caused heat stroke are obese, febrile, have underlying pre-existing conditions like cystic fibrosis or diabetes, or recurrent vomiting and diarrhea. Infants and toddlers are particularly vulnerable to environmental heat stroke when overdressed, left in parked cars, or confined in a hot tub, sauna or any enclosed space.	<p><TG PAGE 3-47></p>

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TRAINEE TEXT	INSTRUCTOR NOTES
<p>d. Children are seldom aware of the early signs of cold such as numbness, and may not be as compliant as adults in wearing appropriate covering. Pre-pubertal children with cold injuries can be at risk for growth plate injury and subsequent poor bone growth, especially of fingers and toes. When removing the child from the cold environment, make sure to advise changing wet clothes for dry coverings.</p> <p>7 - Bleeding (Traumatic Incident Type)</p> <p>1. Background:</p> <p>a. Bleeding can be categorized as having two sites of origin, internal or external.</p> <p>b. Vomiting blood, bleeding from the rectum or untimely vaginal bleeding should always be considered more serious than external bleeding.</p> <p>c. External bleeding can be categorized as either being venous (dark red oozing blood) or arterial (bright red spurting blood). In either case the EMD must remember that ninety-five percent of all external bleeding can be controlled with direct pressure.</p> <p>d. The caller may be frightened by what appears to be a volume of blood. Reassure the caller and calm them.</p> <p>e. The EMD should not advise using pressure points or tourniquets. If the bystanders have already applied a tourniquet, leave it on the patient and allow the on-scene personnel to deal with it.</p>	<p><TG PAGE 3-48></p> <p>Review the Bleeding complaint type.</p>